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ABSTRACT

The study described in this paper is the result of a review of research projects investigating mandatory continuing education (MCE) in Florida. These studies investigated the field of nursing, only one of more than 20 professional groups for which continuing education is mandated. The study found that MCE appears to have some positive features as well as negative ones. MCE has enhanced rather than hindered the provision of opportunities for nurses' professional growth and development. It has created broader opportunities from which individuals can choose and it has encouraged employers and other interested parties to engage in the provision of continuing education. However, the MCE system is not yet perfectly developed, and professional adult educators seem to have only nominal interest in qualitatively affecting the system through their direct contributions. Adult educators could be instrumental in affecting administrative procedures and the criteria for approving, monitoring, and evaluating provider and target population activities. The paper concludes that facilitating learner compliance with MCE demands attention to influences on the learner. These influences include the following: (1) mandated requirements; (2) individual desire for professional growth and development; and (3) personal characteristics such as self-confidence, need fulfillment, and ambition. Success will depend not only on working with the learners, but also with the systems that establish criteria for quality MCE programs and the providers who design and deliver those programs. Adult educators must expand their focus to include the role and responsibilities of employers in the provision of MCE. (KC)

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WHAT CAN ADULT EDUCATORS DO TO FACILITATE LEARNERS' COMPLIANCE WITH PROFESSIONAL CONTINUING EDUCATION REQUIREMENTS?

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WHAT CAN ADULT EDUCATORS DO TO FACILITATE LEARNER'S COMPLIANCE WITH PROFESSIONAL CONTINUING EDUCATION REQUIREMENTS?

The mere mention of the words "mandatory continuing education" evokes an almost knee-jerk response from many professionals. Seldom is the response neutral. This is unfortunate since emotions can distort one's perceptions of reality. Alternatively, a stance of disregard or indifference signals lack of commitment to affect the development, operation, and outcomes of mandatory continuing education endeavors. Change agents, whether educational or non-educational, have two choices to make in attempts to affect change: 1) they can work within or through the system to be changed; or 2) they can work outside the system with external proponents or antagonists (Schaller, 1972). Indifference and disregard can exist both within and outside the system as can support and detraction. Unfortunately, many adult educators are contemptuous and outraged over the seeming disregard of mandatory continuing education (MCE) for the participant's right to freedom of choice concerning their own professional development. Others energetically apply their instructional and design technologies without knowing or caring how the total system functions, or whether their efforts are most effectively being used to better help the system improve the quality of professional practice. While some may be "hired guns working for whomever pays for their services, others wear white hats or dark hats, the color of which is largely dependent upon the observer's biased perceptions. All too infrequently, the

adult educator may have a purposeful neutrality, mixed with cautious optimism that the MCE system can indeed accomplish its purpose of improved professional practice while enhancing freedom of choice to individual professionals.

The information reported in this paper is the result of a series of research projects which sought to better understand MCE in Florida. These studies investigated the field of nursing, only one of the twenty plus professional groups for which continuing education is mandated.

The original impetus for this line of inquiry was the observation of considerable variation in the nature and extent of participation in MCE demonstrated by individual nurses. The original research question was "why". Increasingly the question has become "why not". As we have progressed, it has become abundantly clear that a number of very basic questions about MCE have not been addressed by our colleagues. One such question pertains to the nature of the adult education system that is operating in MCE and how it differs from the "traditional" models assumed by many adult education academicians and practitioners. The overall purpose of this paper is to summarize some of the more salient findings that have been derived from our explorations of mandatory professional continuing education in Florida. More specifically, it shall address: a) the emerging model of the continuing education system as it is currently functioning; b) the motivational orientations of nurses associated with participation in MCE; c) the changes in numbers and kinds of continuing education providers since the inceptions

of MCE; d) the influence of employer sponsorship on MCE participation and e) the deterrents and facilitators to participation in MCE. These topics provide valuable insight into the relationships between adult educators and learners functioning within the constraints of mandated professional continuing education.

THE EMERGING MODEL

Obviously, the question of "what can adult educators do?" is dependent on one's conceptualization of who, or what the adult educator is. Traditionally, academic adult educators have addressed such phenomena as adult learning and program development as if one generic model of learning and development could encompass the broad array of possible client groups, program areas, institutional auspices and societal missions. While a "systems" approach may be frequently utilized in building technical models of program development or learning processes, the "system" of adult education that inputs into, affects and controls learning and development has been largely ignored. Practicing adult educators have not contributed to this void since for any given practice setting, the dictates of goals, resources, organizational arrangements, and target populations are usually within the realm of situational givens. This has hampered conceptualizations of the overall field and the political, social and technical skills needed to effectively install and operate complex adult educational systems. Conceiving adult education as "the process by which men or women their skill, knowledge, or sensitiveness' or it is any process by

which individuals, groups, or institutions try to help men or women improve in these ways" (Houle, 1972) does not provide the specificity of ends or means necessary to give concerted direction to mandatory continuing education. Likewise, conceiving the adult educator as "one who has some responsibility for helping adults to learn..." (Knowles, 1980) provides little room for those who are instrumental in formulating and operating vast systems whose sole purposes may be to initiate decisions, promulgate rules, design reporting procedures, approve providers, employ instructional designers, and market educational offerings. To conceive that the adult educator's mission is to meet the needs and goals of individuals and of society without accepting that there is also a mission to meet the needs and goals of institutions is to foreclose on the concerns of organizations and professional groups for generating, operating, and supporting educational endeavors for employees and constituencies.

The "system" of adult education that has emerged from our studies is constituted by five domains of interest and practice. These domains, portrayed in Figure 1, include two levels of

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Insert Figure 1 about here

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policy concern. The Policy Formulating Domain establishes the initiating structure and the general "rules" within which each other domain must conform. In MCE, this domain is usually a state legislature. Alternatively, it may be a body that has responsibility and authority to regulate constituent groups such

as state education departments and medical societies.

The responsibility of the second domain is Policy Implementation. This domain must interpret and operationalize the decisions and mandates of the Policy Formulation Domain. While there are many forces that affect the operationalization of formulated policy (McLanahan, 1980), the basic task of this domain is to promulgate and administer rules, regulations, and procedures within the constraints established by the Policy Formulation Domain. In Florida, this domain is the State Board of Nursing. Each of the other professions which possesses mandatory continuing education requirements also has a Board which functions within the purview of the Florida Department of Professional Regulation.

The third domain consists of the Target Population for MCE efforts. Traditionally, this domain has been conceived as being constituted of individual registered nurses. Increasingly, various professional nursing associations and employers have perceived them as not just individuals, but as groups of like-minded professionals clustered around a particular area of professional practice or around the operation of a specific, and given, health care provider organization.

Interjected within these initial domains are the Providers of Continuing Education that design and conduct MCE offerings within the constraints imposed by the Policy Implementation Domain. For the Target Population to receive appropriate credit for continuing education participation, they must attend educational offerings sponsored by providers who have demonstrated specific

conditions of educational and administrative practice and been certified as providers by the State Board of Nursing,

The fifth, and final domain in our emerging model consists of Employers. This is the most nebulous of the several domains. On the one hand, the employer may be a non-health care organization, such as a school, a manufacturer, or a voluntary association. On the other hand, the employer may be a complex of health care facilities incorporating the skills of many and diverse health services, such as in a hospital. Other health care systems may be less complex, such as a doctor's office or health maintenance organization. In Florida, many of the employers have also become providers for their own employees, and often for the employees of other health care settings. This is especially true for hospitals.

Given these several domains and their functions, it is apparent that each contributes in its own unique way to continuing education programming. Each contributes differentially to the standard programming procedures of analysis and problem identification, needs assessment, planning, designing, implementation and evaluation, as well as reporting of outcomes. The question "What can adult educators do..." becomes complex and multifaceted. There is no single adult educator or adult educational agency responsible for the overall MCE effort. The MCE system is composed of several domains which are inextricably intertwined in their operations. Few consider themselves to be "adult educators". Unfortunately, academic and agency based adult educators traditionally conceive of their

function primarily within formal educational institutions and at the instructional and design levels. They fail to function at the Policy Formulation or Policy Implementation levels. Further, they often do not work significantly with Providers or Employers in their efforts to analyze situations, assess needs, plan and design educational or organization interventions, conduct and monitor program implementation and evaluate individual and organizational impact of educational offerings. One could speculate that adult educators have relegated themselves to the role of either competing providers or as instructional technologists rather than being system or organizational change agents.

MOTIVATIONAL ORIENTATIONS OF THE TARGET POPULATION

The initial impetus of our concern with MCE was the wide variation that was noted in the participatory behavior of nurses in continuing education, even when mandated requirements existed. A study of the participation of 500 registered nurses was initiated to explore some of the factors which might be associated with this variation. Boshier's Educational Participation Scale (EPS) was used to measure motivational orientations as a potential explanatory variable (Boshier, 1971). The results, while interesting, were disappointing. Of the motivational orientations encompassed in the EPS, none were perceived to be a strong positive influence on participation by the group of nurses in the sample. Cognitive interest and professional advancement were perceived to be of some positive influence. The multiple correlation between participation and

motivational orientations, while statistically significant, accounted for less than 5% of the variance found in participatory behavior. Clearly, other factors or variables were also influencing continuing educational participation.

The findings from this study did corroborate the variations observed in continuing education participation. While the mandate requires 24 hours of continuing education each biennium, it was found that 15% of the respondents reported taking less than this amount. The majority of these nurses had conditions such as recency of original license, recent move into the state, etc, which exempted them from the total amount. On the other hand, 39% reported a total of 35 hours or more. Nurses who participated in more than the required number of continuing education hours tended to be somewhat younger, less experienced, and more likely to be unmarried than those who participated less.

Variation also occurred in the content areas chosen by nurses. Of the eight general content areas in which continuing education is categorized by the State Board of Nursing, 21% of the respondents reported activities in one content area only, 23% reported activities in two areas, 24% in three areas, and 32% in four or more areas. Findings regarding the participation of this random sample of registered nurses were largely supported in a similar study of school nurses employed by school districts and public health departments (Roland, 1986).

CONTINUING EDUCATION PROVIDERS

According to the available data, when MCE became effective in January, 1979, 200 providers were approved by the State Board of

Nursing. In 1982, at the close of the first biennium, the number of approved providers had reached 673. This represented an increase of over 300%. By July, 1986, the total approved providers had reached 858. As indicated on Table 1, hospitals have been, and continue to be, the dominant provider, although

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Insert Table 1 about here

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the percentage has declined to half the original percentage. Educational institutions have also shown relative declines as providers of MCE. Conversely, paramedical and independent providers have experienced phenomenal growth.

Clearly, the configuration of providers has changed since the inception of MCE, with general growth in the number of providers. One could speculate on whether these trends are good or bad, especially with the decline in the percentage of provider educational institutions and hospitals (the largest employers of nurses). On the one hand, growth has spurred a competitive market where providers compete for the participation of nurses. In effect, nurses now have four times as many providers from which to choose than they had prior to the inception of MCE. Such an increase in options is to the advantage of nurses with specialized professional needs and those not employed by hospitals. However, the trends have reduced the influence of educators who work in formal educational institutions or with hospital MCE providers. Our observation is that adult educators are increasingly preparing individual nurses for educational

positions in health provider systems but have made little or no progress in working with the newly emergent, and increasingly dominant providers from other agency and institutional settings.

EMPLOYER SPONSORSHIP

The advent of MCE not only resulted in a proliferation of new provider organizations, it also contributed to an expansion of employer based CE programming. A frequent criticism of MCE is that nurses unmotivated to develop their professional competencies will likely take programs which are the most convenient, least costly and least demanding. Since the dominant CE provider ---hospitals--is also the largest employer of nurses in Florida, the researchers sought to determine the relationship between employer sponsorship and participation. Data obtained from a random sample of registered nurses were reanalyzed using the key variables of nurses' participation in programs sponsored by a) employers only, b) non-employers only, or c) a combination. Sixty-eight percent of the respondents indicated that their employer was also the sponsor of a majority of their continuing education. Other providers identified by respondents included private providers (30.8%), educational institutions (28.%), professional associations (24.2%), public hospitals (18.1%), and other (8.1). While these data did reinforce the tentative contention that nurses would engage in CE that was most accessible, it forced some reconsideration of the relative importance of the various MCE providers in Florida. Participation in the CE offerings of educational institutions far exceeded the relatively small proportion of CE providers they

represented. Likewise, professional associations attracted participants far exceeding their relative proportion among all providers. Given that hospitals are the dominant employer, and the relative proportion of respondents reporting CE from public hospitals, it appears that these settings retain a dominant influence on MCE programming activities.

The findings did not wholly support our somewhat pessimistic notions about nurses' reasons for participation. Some distinct patterns emerged as the analyses were conducted on who participated in what provider categories and content areas. It was found that younger nurses enrolled in general nursing practice were more likely to be engaged in MCE from their provider. Those who were older and enrolled in specialized nursing areas were more likely engaged with non-employer providers. Interpretations of these data suggests that CE offered by employers is more likely concerned with current job responsibilities whereas that provided by non-employers is used by nurses to gain specialized skill and achieve advancement in their careers. By implication, one can conclude that the CE offered by various providers is not only diverse in its content, but in its appeals to the present job (training) or future job (education) perspectives of potential participants. Without the wide array of educational offerings promulgated by MCE requirements, one could speculate about the availability of opportunities for nurses to prepare for positions beyond their present job. While present job training must be considered crucial, adult educators must insure that opportunities for

advancement and professional mobility are made available. Unfortunately, we have found little or no interest on the part of most institutions in systematic career development for nurses. Planned and purposeful career development still appears to be relegated to the realm of individual choice, or chance.

DETERRENTS AND FACILITATORS

While our data support the contention that MCE has had an effect on the development of alternative educational opportunities for nurses in Florida, they do not support motivational orientations as a dominant influence affecting variations in participation. Cross (1981) identified situational, institutional and dispositional barriers to learning that are translatable to deterrents to participation. Scanlan and Darkenwald (1984) also sought to explain some variations in participation through the study of deterrents, utilizing their Deterrents to Participation Scale. In our studies, previous work was expanded to consider both potential deterrents and facilitators through the use of a 38 item Likert type scale which examines personal/family, professional and provider influences. Preliminary analyses of these data suggest that both positive and negative forces influence participation. Overall, there are more positive influences on participation than negative. The most predominant positive influences relate to program characteristics, job and employment conditions, desire for professional growth and development, self confidence and ambition. The dominant negative influences were child care and recent retirement. Only a few of the positive influences

identified (provision of opportunities to meet mandated requirements, subject content, and usefulness of the program) are subject to the control and influence of the adult educator.

CONCLUSIONS

Given the reported findings, the authors have developed a sense of cautious optimism about the future of mandatory continuing education. Contrary to the negative reactions from some, MCE appears to have some positive features as well as negative ones. We can cautiously conclude that MCE has enhanced rather than hindered the provision of opportunities for nurses' professional growth and development. It has created broader opportunities from which individuals can choose and it has encouraged employers and other interested parties to engage in the provision of CE. However, the MCE system is not yet perfectly developed and professional adult educators seem to have only nominal interest in qualitatively affecting the system through their direct contributions.

While the Policy Formulation Domain has not always asked for our input, it is subject to the intercessions of various interest groups--a strategy adult educators appear disinclined to pursue. The Policy Implementation Domain has the complicated task of interpreting and operationalizing policy mandates. Adult educators working with this domain could be instrumental in affecting not only administrative procedures, but more importantly, the criteria for approving, monitoring and evaluating provider and target population activities.

Consistent with the overall field of adult education,

providers represent a widely diverse array of agencies, institutions, and individuals. All of these providers must plan, design, implement and evaluate MCE offerings. The task with this group is for adult educators to reach out and market our competencies. Employers and target populations need assistance in assessing their professional situations and in making their needs known to Provider and Policy Implementation Domains. While work with employer/providers would be especially useful, the subject areas with which the providers work are often foreign and forbidding to generalist adult educators. Thus, generalist adult educators will need to reconstruct their traditional "individual change through education" to a more "organizational change through human resource development" approach. Adult educators will have to seriously consider whether we work primarily through formal educational institutions and deal with generalized programming and adult learning models or whether we need to focus our endeavors with intent and specificity on the rigors and demands of mandatory professional continuing education.

In summary, if we are to facilitate learner compliance with mandatory professional continuing education, then we must be concerned with what influences the learner. Our findings indicate that there are several influences on the participation behavior of the learner: 1) mandated requirements; 2) individual desire for professional growth and development; 3) personal characteristics such as self confidence, need fulfillment and ambition. This suggests that we need to work not only with the target population of learners, but that we need to work with the

individuals and systems who establish criteria for quality MCE programs, and the providers who design and deliver those programs. Moreover, since the work environment of the target population is largely affected by the employer (and many employers are providers), adult educators must expand their focus to include the role and responsibilities of the employing institution in the provision of mandatory professional continuing education.

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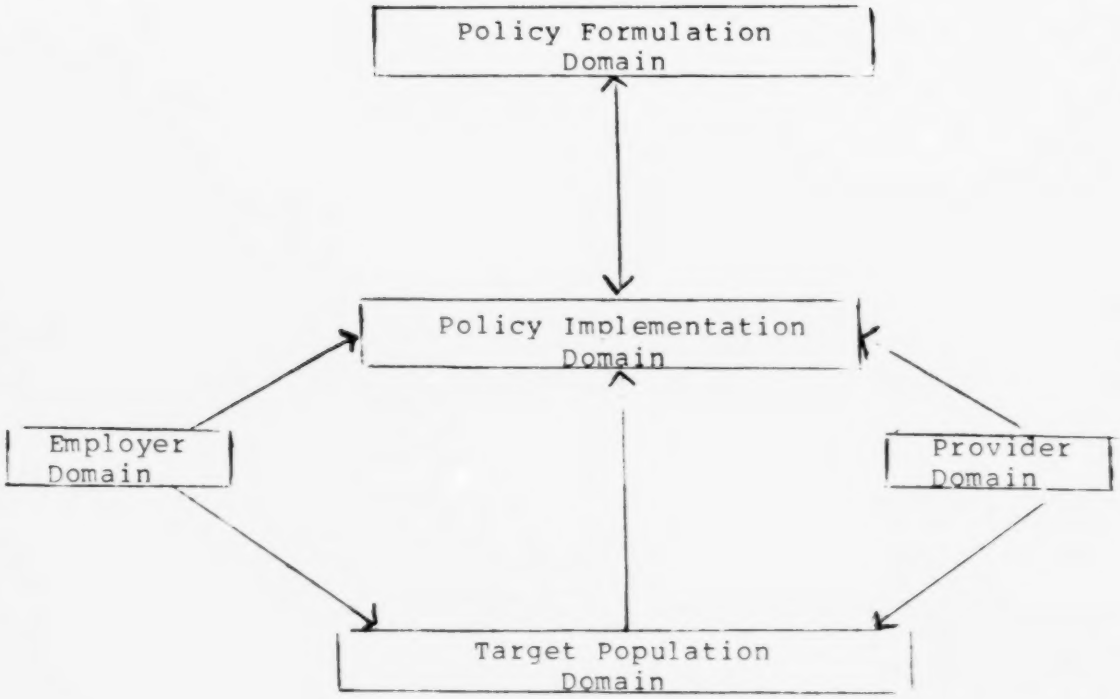

Figure 1: An Adult Education System--The Domains of Mandatory Continuing Education

Table 1

Approved Continuing Education Nursing Providers In Florida

Provider	January, 1979 Number	January, 1979 Percent	February, 1982 Number	February, 1982 Percent	July, 1986 Number	July, 1986 Percent
Hospital	126	63.5	225	34.4	259	30.2
Educational Institution (College, University, vocational school)	26	13.0	57	8.7	66	7.7
Independent	23	11.5	133	20.3	205	23.9
Nursing Association	10	5.0	70	10.7	63	7.3
Home Health Agency	6	3.0	38	5.8	52	6.1
Public Health	6	3.0	23	3.5	31	3.6
Paramedical	3	1.5	94	14.4	153	17.8
Nursing Home	0	0.0	14	2.1	29	3.4
Total	200	100.0	654	100.0	858	100.0

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